Assumption Life

Psychological or Nervous Disorder Questionnaire

First Name : _____ Last Name : _____

Policy Number : _____ Date of Birth (DD/MM/YYYY): ____/____/_____

1. In the last 10 years, have you been diagnosed with, treated for or had any symptoms or indication of any psychological, emotional or nervous disorder? ❑ Yes ❑ No
   If yes, please indicate the medical diagnosis and proceed with the following questions. If no, please date and sign at the bottom of the questionnaire. Medical diagnosis: _____
   Was any cause identified? ❑ Yes ❑ No
   If yes, please give details. _____

2. Please indicate which of the following apply to your condition, and provide us with further details :

Symptoms	**Details (dates and duration)**
❑ Insomnia	_____
❑ Fatigue	_____
❑ Nervousness (anxiety)	_____
❑ Depressed mood	_____
❑ Suicidal thoughts	_____
❑ Suicide attempt(s)	_____
❑ Other (specify):_____	_____

Referral	**Details (dates, duration, name of physician)**
❑ Therapy	_____
❑ Referral to a psychologist	_____
❑ Referral to a psychiatrist	_____

3. Date you first experienced symptoms : _____

4. Frequency of symptoms (daily, weekly, monthly, etc.): _____

5. Date of your last symptoms: _____

6. Are you <u>currently</u> taking any medication for these conditions? If yes, please list the name of any medication. ❑ Yes ❑ No
   _____

7. Have you <u>ever</u> taken any medication for these conditions in the past, other than those listed in question 6? ❑ Yes ❑ No
   If yes, please list the name of the medication(s) and date(s) taken:
   _____

8. Was any hospitalization required for any of these conditions? ❑ Yes ❑ No
   If yes, dates and duration: _____

9. Was any time off work required for any of these conditions? ❑ Yes ❑ No
   If yes, dates and duration: _____

10. Do you consume alcohol or drugs (other than mentioned above)? ❑ Yes ❑ No
    If yes, please confirm if alcohol, drugs or both and your weekly consumption: _____
    _____

11. Do you have any pending consultation or treatment? ❑ Yes ❑ No
    If yes, please provide details (date, treatment, name of attending physician). _____
    _____

12. Name of personal physician: _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

_____ _____

Signature of proposed insured (parent or legal guardian if a minor) Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
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